PREVENTION PARTNERS

REGIONAL SCREENING

Prevention Partners offers *Regional Screenings* for retirees and for those that have missed a screening held at their own worksite. Those subscribing to the State Health Plan, BlueChoice, Cigna, and MUSC Options will have the opportunity to participate in a *Regional Screening* on **Wednesday, October 15, 2008 at the Catawba Regional Center, located at 215 Hampton Street in Rock Hill, S.C.**

NOTE: If your school or agency does not host its own *Worksite Screening*, please go to www.eip.sc.gov, (click on Prevention Partners, and go to "Coordinator Materials") and see Worksite Screening Request Form. All schools and agencies should be trying to host their own *Worksite Screening*. Anyone can volunteer to coordinate it. Coordinating a *Worksite Screening* is easy and requires very little time.

Screening Components

Health risk appraisal:

- This screening includes a complete wellness profile

Lipid profile, including:

- Total cholesterol.
- Low density lipoproteins (LDL).
- High density lipoproteins (HDL).
- Triglycerides.

Chemistry profile including:

- Blood Urea Nitrogen (BUN) and creatinine. These tests help measure and assess kidney function.
- Glucose. This test measures blood sugar level.
- Electrolytes. This test measures Sodium, Potassium, Chloride and Bicarbonate. These four elements control the body's pH (acid/base) balance.

Hemogram, including:

- Red and white blood cell count
- Hemoglobin
- Hematocrit

Also includes Blood Pressure, Height and Weight

Registration

This screening is available for just a $15 co-payment. To register you need to complete the registration form below and return it to Prevention Partners Screening, 1201 Main Street, Suite 300, Columbia, SC 29201 **along with a check for $15 made payable to Carolina Occupational Health Screening Group (or COHSG).**

You will be notified of the earliest appointment time available by email.

If you have any questions, please email emcelveen@eip.sc.gov.

REGISTRATION FORM: Rock Hill, S.C. – October 15, 2008

(Registration deadline: September 30, 2008)

Terms and Conditions

- There is a 12-hour fast prior to your screening (you may have water and any required medications you may be taking)
- Participants are required to complete all components of this health screening. This includes height, weight, blood pressure, blood draw, and paperwork.
- Your insurance card ID number will be required the day of the screening for claim filing
- Insurance allows for **ONE** Prevention Partners screening per calendar year (January-December)
- Spouses covered by eligible employees and retirees can participate for a $15 co-payment
- Dependent children are not eligible
- If Medicare or Tri-care is your primary insurance, you are not eligible
- **SCHEDULING:** Please understand the difficulty in scheduling large *Regional Screenings* screenings. It is impossible to honor every request for an early appointment time. To be fair, appointment times are assigned on a first come, first serve basis. Checks and registration forms will be kept in the order that they are received, with those responding earliest receiving the earliest appointment times. **Appointment times will be assigned on the day of the registration deadline via email.** By registering for this screening, you acknowledge that you understand that your appointment time could range anywhere between 8:00 AM and NOON. If an appointment time anywhere in this time frame is not acceptable due to a medical condition, work schedule, etc., it may be in your best interest to be screened through your personal physician or host a *Worksite Screening* at your own school or agency.

Name:_____ Work Phone:_____ Home/Cell Phone:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Email (**REQUIRED-PRINT CLEARLY**): _____

To participate, your primary insurance must be one of the following (check one):

____ State Health Plan ___ BlueChoice __ Cigna ___ MUSC Options

I hereby certify that I am an employee, retiree or covered spouse with insurance coverage through the state of South Carolina and that I have read the terms and conditions listed above. I understand how scheduling is done. I affirm that the information I've given is true and correct. Any discrepancy may result in further billing by the provider.

SIGNATURE_____ Insurance Card I.D. Number (not your SSN#):_____